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Third Interim Report on MEDICAL ASSISTANCE IN DYING IN CANADA

Canada

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Publication date: June 2018

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Cat.: H14-230/3-2018E-PDF
ISBN: 978-0-660-26157-7
Pub.: 180006

INTRODUCTION

Canada's federal legislation on medical assistance in dying was enacted on June 17, 2016. Since then, governments have been working together to support the integration and implementation of medical assistance in dying within the Canadian health care system. Many provinces and territories have put in place coordination systems or interprofessional care teams to help individuals seeking information on and assessments for medically assisted dying. Some Canadian jurisdictions have also made legislative and system-level policy changes to further integrate assisted dying as a part of the range of end-of-life care services available to Canadians. The federal government has also contributed to making current information about medical assistance in dying readily available to Canadians through its directory of national and provincial/territorial contacts on its Canada.ca Medical Assistance in Dying web pages.

In virtually all countries that permit some form of assisted dying, public reporting is considered to be a critical component of providing transparency and fostering public trust in the application of the law. The need for public reporting also reflects the seriousness of medical assistance in dying as an exception to the criminal laws that prohibit the intentional termination of a person's life.

The federal legislation on medical assistance in dying authorizes the Minister of Health to make regulations to support data collection and reporting on requests for, and the provision of medical assistance in dying. Health Canada expects to have these regulations in place in the fall of 2018. More information about the implementation of the permanent federal monitoring and reporting system for medical assistance in dying is provided later in this report.

Until a permanent system is in place, federal, provincial and territorial governments have been working together to produce interim updates using available data. The first update was released on April 26, 2017, providing information on the first six months (June 17 to December 31, 2016) of medical assistance in dying under federal legislation. The second update was released on October 6, 2017 and covered the next six month period (January 1 to June 30, 2017) providing insight into the implementation of medical assistance in dying in its first year. **The data provided in this report, covering the period from July 1 to December 31, 2017**, offers the most comprehensive profile of medical assistance in dying in Canada to-date.

IMPLEMENTATION OF MEDICAL ASSISTANCE IN DYING

While the federal legislation sets out a consistent framework under which medical assistance in dying is accessible to Canadians, it is provincial and territorial governments that are responsible for the management and delivery of health care services and for law enforcement, generally. Jurisdictions continue to implement legislative changes or policies related to the delivery and oversight of medical assistance in dying across the country.

To increase awareness among practitioners and improve service delivery, a number of jurisdictions are offering education and training programs on medical assistance in dying for practitioners. For example, Ontario is supporting the implementation of in-person and online sessions of an Advanced Course on Medical Assistance in Dying delivered by Joule, a subsidiary of the Canadian Medical Association (CMA). British Columbia is supporting access to training for physicians in rural communities by implementing the Medical Assistance in Dying Travel and Training Assistance Program. This program provides health authorities with funding to support the delivery of medically assisted dying services in rural communities.

Newfoundland and Labrador is also implementing a provincial training initiative for each of its Regional Health Authorities. For registered nurses and nurse practitioners, the Canadian Nurses Association has recently introduced an online education module on Medical Assistance in Dying: What Nurses Need to Know.

In 2017, the Canadian Association of MAID Assessors and Providers (CAMAP) was established to offer peer support, research and advocacy for all professionals involved in medical assistance in dying, as well as for patients and families. www.camapcanada.ca provides a library of resources. In addition, CAMAP holds annual conferences to share information and engage in discussions about emerging challenges and interpretations of the legislation on medical assistance in dying.

Media reports have also highlighted various challenges encountered in obtaining medical assistance in dying. Some of these reported challenges include: securing access for those living in communities with insufficient providers and/or with limited access to care coordination services; patients seeking this service in faith-based institutions; and situations where providers exercise their conscience rights by refusing involvement in assisted dying. In some jurisdictions, particularly in Ontario, measures have been taken to facilitate access by requiring practitioners who conscientiously object to providing a health service, including medical assistance in dying, to provide an effective referral[1] for their patients.

The federal legislation clearly states that no individual can be compelled to provide or assist in providing medical assistance in dying. The law does not, however, define where assisted dying should be provided. Provinces and territories as well as health care institutions determine how best to deliver health care services to meet the needs of their residents. They are able to create health-related policies on how and where medical assistance in dying is provided, in so far as those policies are consistent with the federal legislation. It is expected that how this service is organized, delivered, and monitored will evolve as more data becomes available to support the evaluation of existing policies and service delivery models.

METHODOLOGY AND PARAMETERS

As was the case for previous reports, provincial governments provided Health Canada with information available in their jurisdiction on medical assistance in dying. The territories (Yukon, Northwest Territories and Nunavut) could not share any data for this reporting period due to small numbers and associated concerns for the privacy of patients and providers involved.

Under the province of Quebec's *Act Respecting end-of-life care*, physicians and health and social services institutions in the province are required to report information on medical aid in dying to Quebec's Commission on End-of-Life Care. The Commission is required to submit annual reports to Quebec's Minister of Health and Social Services. Additionally, all health and social services institutions in Quebec are required to publicly report on three specific data points: the number of requests for medical aid in dying received, the number of requests completed and the number that were declined (including reasons why). In this report, Quebec's data for the period of July 1 to December 31, 2017 was compiled from available public reports posted on the websites of individual health and social services institutions[2] in the province.

1 See for example: College of Physicians and Surgeons of Ontario, Fact Sheet "Ensuring Access to Care: Effective Referral – www.cpso.on.ca/cpsomedia/documents/policies/policy-items/medical-assistance-in-dying-effective-referral-factsheet.pdf.

2 At the time this report was prepared, two health and social services institutions had not yet released their reports for the reporting period established by the Commission (from June 10 and December 9, 2017). As such, the numbers reflected in this report do not represent a complete accounting of medical assistance in dying in Quebec for this timeframe, and numbers are likely to increase slightly upon release of these reports.

as well as the Collège des médecins du Québec[3]. While these public reports do not represent an official record of the Government of Québec[4], they do provide a reliable source of data.

Table 1 provides the number of medically assisted deaths in Canada during this reporting period when all of these parameters are considered. Table 1 also provides the total number of Canadians who have received medical assistance in dying since legislation came into force on December 10, 2015 in the province of Quebec, and on June 17, 2016 in the rest of Canada.

Table 1. Number of Medically Assisted Deaths in Canada[1]

Medically assisted deaths provided between **July 1 and December 31, 2017**	1,525[2]
Total number of medically assisted deaths in Canada since enactment **(between December 10, 2015 and December 31, 2017)**	3,714[3]

[1] Due to small numbers and associated privacy concerns, data from the Yukon, Northwest Territories, and Nunavut was not included.

[2] Number includes data compiled from publicly available reports posted on the websites of Quebec's health and social services institutions and the Collège des médecins du Québec, but does not represent official numbers from the Government of Québec.

[3] Number includes provincial data (excluding official numbers from Québec as reported in past federal interim reports and the number of medically assisted deaths in Québec as reported by Québec's Commission on End-of-Life Care for the period between December 10, 2015 and June 9, 2017. This number also includes two cases that were initially unreported in Ontario during the production of the first interim report.

TOWARDS A PROFILE OF MEDICAL ASSISTANCE IN DYING IN CANADA

This third interim report provides further insight into the profile of medically assisted deaths and the characteristics of those Canadians who choose medical assistance in dying. A brief discussion on this topic can be found in the **Summary of Findings** section below.

NATIONAL PROFILE OF MEDICAL ASSISTANCE IN DYING

For this reporting period, most provincial governments were able to provide basic demographic information on persons receiving medical assistance in dying, the settings in which medically assisted deaths occurred, and the most common underlying medical condition of those receiving medical assistance in dying. Table 2 presents nationally-aggregated data on these elements. In instances where there were fewer than seven cases on a particular measure, the data has been suppressed to protect the privacy of the patients and providers involved.

3. The Collège des médecins du Québec collects reports directly from individual private practice physicians in the province.

4. Official reports on medical aid in dying in Québec are prepared by La Commission sur les soins de fin de vie and are tabled in the Assemblée nationale du Québec by the provincial Minister of Health and Social Services. The Commission's 2nd annual report, which includes data on medical aid in dying in Québec from July 1, 2016 to June 30, 2017, was tabled in the Assemblée on October 26, 2017.

Table 2. Profile of medically assisted deaths and persons receiving medically assisted deaths in Canada, 2017 (excludes: Quebec, Yukon, Northwest Territories and Nunavut)

	January 1 to June 30, 2017	July 1 to December 31, 2017
Total number of medically assisted deaths	875	1086
Number of clinician-administered deaths	874	1086
Number of self-administered deaths	1	0
Number of medically assisted deaths by clinician:		
Physician	837 (95.7%)	1031 (95%)
Nurse Practitioner	38 (4.3%)	55 (5%)[a]
Settings in which assistance in dying occurred:		
Hospital	368 (42%)	440 (40.5%)
Patient's home	350 (40%)	470 (43.3%)
Long-term care facility or nursing home	78 (9.0%)	58 (5.3%)
Hospice[b]	–	32 (2.95%)
Other[c]/Unknown[d]	79 (9.0%)	86 (7.9%)
Age range of persons:		
18–45	18	16
46–55	39	51
56–64	150	159
65–70	144	171
71–75	124	144
76–80	119	166
81–85	102	145
86–90	88	135
91+	68	76
Unknown[d]	23	32
Average age	73	73
Proportion of men and women	53% Men 47% Women	49% Men 51% Women
Proportion of person in large urban centres[e] versus smaller population centres	57.1% Large centres 42.9% Smaller centres	55.9% Large centres 41.6% Smaller centres 2.5% Unknown[d]
Most common underlying medical circumstances of those who received a medically assisted death		
Cancer-related	63%	65%
Neuro-degenerative	13%	10%
Circulatory/Respiratory system	17%	16%
Other causes/Unknown[d]	7%	9%

[a] Due to small numbers of nurse practitioners having provided medical assistance in dying as reported by some provinces, this number is not presented in the provincial profiles.

[b] For the previous two reporting periods, "hospice" was not singled out due to suppression of small numbers but had been included in the "Other" category.

[c] Other may include: retirement homes; assisted or supportive living; ambulatory setting; day program space; clinician's office; funeral home; hotel/motel; hospices (for Jan to Jun 2017 and July to Dec 2016); or, undisclosed.

[d] Unknown includes data that was suppressed by provinces due to smaller numbers (less than 7) and associated privacy concerns.

[e] According to Statistics Canada, a large urban centre consists of a population of 100,000 or more.

REQUESTS FOR MEDICAL ASSISTANCE IN DYING

In addition to the core data elements presented in Table 2, Alberta, Saskatchewan, Manitoba, Quebec (as required under its provincial legislation), and some of the Atlantic provinces were able to provide additional details about **the number of requests for medical assistance in dying**, and **the number of requests that were declined, withdrawn or unfulfilled**. There is a growing interest in better understanding those instances where medical assistance in dying was provided, as well as where it was not provided, as it may offer insight into the medical circumstances of those requesting this service across Canada.

Table 3 provides a profile of requests for medically assisted deaths where comparable measures exist. Due to the variations in the collection of data in these provinces, the **number of requests declined** and **those that were withdrawn** are not presented numerically in Table 3. However, they are provided in the **Provincial Profiles** found in Tables 4a and 4b (where available) and are broadly discussed in the **Summary of Findings**.

Table 3. Profile of Requests for Medically Assisted Deaths in Select Provinces (AB, SK, MB, QC, NL, PEI, NS)

	January 1 to June 30, 2017	July 1 to December 31, 2017
Total number of requests for medical assistance in dying reported in these provinces	832	1,066
Most frequently cited reasons for why requests for medical assistance in dying have been declined (in order of frequency)*	Loss of competency Death not reasonably foreseeable Other	Loss of competency Death not reasonably foreseeable Other
Number of cases where the individual died prior to the completion of the assessment process	202 (24%)	149 (14%)

* This data point does not include information from the province of Quebec. While the public reports issued by Quebec's health and social service institutions and the Collège des médecins du Québec provide data on the reasons why requests for medical aid in dying were declined, they are not easily categorized according to the criteria in the federal legislation and have not been accounted for in this data element.

SUMMARY OF FINDINGS

As has been the trend in previous reports, the number of medically assisted deaths in Canada has increased over the most recent reporting period. Between July 1 and December 31, 2017, 1,525[5] Canadians receiving medical assistance in dying, an increase of 29.3% since the last reporting period. As shown in Table 1, based on currently available data, 3,714 Canadians have received medical assistance in dying since both Quebec's law and the federal legislation came into force.

Using Statistics Canada's available projections of deaths in Canada[6], medically assisted deaths accounted for approximately 1.07% of total deaths in Canada during this reporting period. As mentioned in previous

5 This total number includes number of assisted deaths in Quebec found in the data retrieved from public reports issued by Quebec health and social service institutions on the application of Quebec's Act Respecting end-of-life care. Those numbers do not however represent an official report from the Government of Quebec.

6 Statistics Canada. Death estimates: www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo07a-eng.htm. In calculating the average percentage increase of deaths (i.e., 2.6%) period to period, a projected estimation of total deaths in Canada for 2017/2018 was calculated. This number was then used to calculate estimated number of deaths in Canada during the reporting period for this 3rd Interim Report (i.e., between July and December 2017).

interim reports, Canada's percentage of medically assisted deaths remains consistent with that of other international assisted dying regimes where between 0.3% to 4%[7] of total deaths have been attributed to assisted death.

Medically assisted death was largely administered by physicians, with only British Columbia, Alberta and Ontario reporting that nurse practitioners in their jurisdictions have provided this service. Of note, Quebec's legislation only permits physicians to provide medical aid in dying. Nurse practitioners provided medical assistance in dying in 5% of all cases reported during this period, representing a 45% increase since the last interim report.

In 2016[8], the Netherlands reported that 80.5% of its assisted deaths occurred at home. In Canada, the setting for the provision of assisted dying continues to be primarily divided between a hospital (40.5% of all assisted deaths) and a patient's home (43.3%), followed by other settings such as long-term care or assisted living facilities. Provision at a patient's home seems to be increasing slightly over provision in a hospital setting. British Columbia continues to have a higher provision of assisted dying in a home setting than other reporting provinces. Past studies have indicated that a majority of Canadians prefer to die at home rather than in hospital. However, provider preference and availability, and the suitability of the home setting, could be some of the factors limiting access to home-based medically assisted dying.

During this reporting period, no cases of self-administration of medical assistance in dying took place. This option for a self-administered medically assisted death remains less prevalent than that of clinician-administration. Anecdotally, this may be a result of patient or clinician preferences, policies established around this type of assisted dying in some jurisdictions, or the availability of clinical protocols to guide the use of effective drugs. Furthermore, self-administration is not a type of assisted dying that is permitted under Quebec's legislation on end-of-life care.

In line with past interim reports, the ages at which the majority of Canadians receive assistance in dying remains between 56 and 90 years old. The average age of persons for whom medical assistance in dying was provided was approximately 73 years old.

There were a greater number of cases of medical assistance in dying in larger urban centres (55.9%) versus centres with smaller populations (i.e. less than 100,000) (41.6%), similar to previous reports. As in previous reports, those receiving assisted deaths were almost equally divided among men (49%) and women (51%). While this data may suggest that there is relatively equal interest in medical assistance in dying between men and women, the collection of additional patient and socio-demographic data through the federal monitoring system will allow for more in-depth analysis in the future.

7 Source: www.dutchnews.nl/news/archives/2017/04/number-of-official-cases-of-euthanasia-rise-10-in-the-netherlands/

8 Source: www.worldrtd.net/news/annual-report-dutch-euthanasia-practice-published

Cancer was again the most frequently cited underlying medical condition associated with an assisted death. It represented approximately 75% of all assisted dying cases by reporting provinces and a 12% increase from the first interim report. In all international jurisdictions that allow some form of assisted dying, cancer is the most frequently cited underlying medical condition among those receiving an assisted death (76.9% in Oregon[9], 69% in Belgium[10], and 68% in the Netherlands[11]). Numbers of assisted deaths for those with neuro-degenerative and circulatory/respiratory conditions did not change significantly since the last interim report.

As outlined earlier in Table 3, some provinces (Alberta, Manitoba, Saskatchewan, Quebec[12] and some Atlantic provinces) collected and provided information to Health Canada regarding requests for medical assistance in dying, including requests that were either declined, withdrawn, or incomplete. The data found in Table 3 and the additional findings below should be interpreted with caution as they represent only a small proportion of the total number of requests for medical assistance in dying. The findings show that of the 1,066 requests for medical assistance in dying reported by these provinces, approximately 8% were declined. The most commonly cited reasons were loss of competency and that death was not reasonably foreseeable.[13] Of these 1,066 requests reported, approximately 5% were withdrawn by the patient. Approximately 14% of requests were unfulfilled because the patient died prior to the completion of the assessment process. This could be attributed to requests being made at a late stage in an individual's illness.

PROVINCIAL PROFILES

Tables 4a and 4b that follow provide provincial breakdowns on a number of elements (where available) used in the national roll up (Table 2). Where there are fewer than seven instances reported in a province on any one data element, the data has been supressed in these provincial reports to protect the privacy of patients and providers involved in medical assistance in dying. However, these numbers were included in the national roll up wherever possible.

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9. Source: www.oregon.gov/oha/PH/PREVENTIVEHEALTHSERVICES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf

10. Source: www.dyingforchange.com/docs/AssistedDyingFactsheetEuthanasiaWhitepaperFeb2016.pdf

11. Source: www.worldrtd.net/news/annual-report-dutch-euthanasia-practice-published

12. Quebec's health and social service institutions and the College des medecins du Quebec are required to publicly report on the number of requests for medical aid in dying as well as on requests that were not completed (including the reasons why). The data from these reports was gathered to contribute to this analysis, however the numbers do not represent an official account by the Government of Quebec.

13. While the public reports of Quebec's health and social service institutions and the College des medecins du Quebec provide information on reasons why requests were declined, they are not easily categorized according to criteria in the federal legislation and have not been accounted for in the data element.

Table 4a. Profile of Medical Assistance in Dying by Province/Region for July 1 to December 31, 2017

	British Columbia		Alberta		Saskatchewan	
Number of contacts or inquiries about medical assistance in dying	N/A		330*		100	
Number of requests for medical assistance in dying	N/A		182		62	
Number of requests for medical assistance in dying that have been declined	N/A		27		23	
Number of requests that were withdrawn by the individual	N/A		Less than 7		Less than 7	
Number of cases where the person died prior to the completion of the assessment	N/A		30		10	
Total number of medically assisted deaths	**365**		**102**		**39**	
Number of medically assisted deaths by setting	109 (30%) Hospital 185 (51%) Patient's home 40 (11%) LTC/nursing home* 19 (5%) Hospice 12 (3%) Other^		35 (34%) Hospital 39 (38%) Patient's home 7 (7%) Hospice 21 (21%) Other^		24 (62%) Hospital 12 (31%) Patient's home (Less than 7) LTC/nursing home (Less than 7) Other^	
Average age of persons receiving assisted death	75.9		72.5		72.5	
Age range of persons receiving medical assistance in dying	**Age Range**	**# of Cases**	**Age Range**	**# of Cases**	**Age Range**	**# of Cases**
	18–45	Less than 7	18–45	Less than 7	18–45	0
	46–55	17	46–55	Less than 7	46–55	Less than 7
	56–64	46	56–64	24	56–64	Less than 7
	65–70	61	65–70	18	65–70	8
	71–75	44	71–75	14	71–75	7
	76–80	61	76–80	9	76–80	8
	81–85	47	81–85	10	81–85	Less than 7
	86–90	52	86–90	16	86–90	Less than 7
	91+	33	91+	Less than 7	91+	Less than 7
	Unknown†	-	Unknown†	11	Unknown†	-
Number of men/women receiving an assisted death	180 (49%) Male 185 (51%) Female		48 (47%) Male 54 (53%) Female		22 (56%) Male 17 (44%) Female	
Number of people receiving medical assistance in dying in large urban centres◊ versus smaller population centres	167 (46%) Large centres** 198 (54%) Smaller centres		69 (68%) Large centres 33 (32%) Smaller centres		26 (67%) Large centres 13 (33%) Smaller centres	
Most common reported underlying medical condition of people who obtain a medically assisted death	239 (65%) Cancer-related 37 (10%) Neuro-degenerative 67 (18%) Circulatory/ Respiratory 22 (6%) Other causes		66 (65%) Cancer-related 11 (11%) Neuro-degenerative 17 (17%) Circulatory/ Respiratory 8 (8%) Other causes		31 (79%) Cancer-related (Less than 7) Neuro-degenerative (Less than 7) Circulatory/ Respiratory (Less than 7) Other causes	

N/A indicates that the data was not collected by the province.

* There is no legal requirement to report requests for medical assistance in dying to the MAID Care Coordination Service at Alberta Health Services. Therefore, there may have been more individuals who contacted or made inquiries to a practitioner, or requested medical assistance in dying from a practitioner, who are not captured in these figures.

^ Other may include: retirement homes; assisted/supportive living; ambulatory setting; day program space; clinician office; funeral home; hotel/motel; undisclosed or suppressed due to small numbers.

† Unknown includes numbers suppressed due to a small number of cases (less than 7) in that province.

* The category LTC/Nursing homes includes: long term care facilities and extended care facilities.

◊ According to Statistics Canada, a large urban centre consists of a population of 100,000 or more.

** The figure for large urban centres in BC excludes municipalities with a population of less than 100,000 that are part of the larger urban Vancouver/Lower Mainland area – i.e., New Westminster, West Vancouver, Maple Ridge, and Port Moody. While Statistic Canada's 2016 census does not consider Victoria a large urban centre, the BC Coroners Service has recorded deaths within the Greater Victoria area as having occurred in Victoria which then includes Victoria in the category of a large urban centre.

Table 4b. Profile of Medical Assistance in Dying by Province/Region for July 1 to December 31, 2017

	Manitoba		Ontario		Atlantic Region (NL, PEI, NS, NB)	
Number of contacts or inquiries about medical assistance in dying	164		N/A		95	
Number of requests for medical assistance in dying	75		N/A		92	
Number of requests for medical assistance in dying that have been declined	30		N/A		8	
Number of requests withdrawn by the individual	15		N/A		Less than 7	
Number of cases where the person died prior to the completion of the assessment	22		N/A		10	
Total number of medically assisted deaths	**33**		**477**		**70**	
Number of medically assisted deaths by setting	18 (55%) Hospital 15 (45%) Patient's home		230 (48%) Hospital 216 (45%) Patient's home 16 (3%) LTC/nursing home[4] (Less than 7) Hospice 10 (2%) Other[5]		24 (34%) Hospital (Less than 7) Patient's home (Less than 7) LTC/nursing home[4] 42 (60%) Unknown[6]	
Average age of persons receiving assisted death	73.0		74.2		70.0	
Age range of persons receiving medical assistance in dying	**Age Range**	**# of Cases**	**Age Range**	**# of Cases**	**Age Range**	**# of Cases**
	18–45	Less than 7	18–45	11	18–45	
	46–55	Less than 7	46–55	24	46–55	Less than 7
	56–64	Less than 7	56–64	70	56–64	11
	65–70	Less than 7	65–70	69	65–70	11
	71–75	Less than 7	71–75	68	71–75	Less than 7
	76–80	Less than 7	76–80	68	76–80	9
	81–85	Less than 7	81–85	75	81–85	Less than 7
	86–90	Less than 7	86–90	57	86–90	Less than 7
	91+	Less than 7	91+	35	91+	Less than 7
	Unknown[6]	–	Unknown[6]	–	Unknown[6]	21
Number of men/women receiving an assisted death	15 (45%) Male 18 (55%) Female		222 (47%) Male 255 (53%) Female		40 (57%) Male 30 (43%) Female	
Number of people receiving medical assistance in dying in large urban centres[3] versus smaller population centres	24 (73%) Large centres 9 (27%) Smaller centres		297 (62%) Large centres 180 (38%) Smaller centres		24 (34%) Large centres 19 (27%) Smaller centres 27 (39%) Unknown[6]	
Most common reported underlying medical condition of people who obtain a medically assisted death	22 (67%) Cancer-related (Less than 7) Neuro-degenerative (Less than 7) Circulatory/ Respiratory (Less than 7) Other causes		294 (62%) Cancer-related 57 (12%) Neuro-degenerative 83 (17%) Circulatory/ Respiratory 43 (9%) Other causes		51 (73%) Cancer-related (Less than 7) Neuro-degenerative (Less than 7) Circulatory/ Respiratory (Less than 7) Other causes 9 (13%) Unknown[6]	

N/A indicates that this data was not collected by a province.

[5] Other may include: retirement homes, assisted/supportive living, ambulatory setting, day program space, clinician's office, funeral home, hotel/motel, undisclosed or suppressed due to small numbers.

[6] Unknown includes either data not collected by a province or region, or numbers suppressed due to a small number of cases (less than 7) in that province or region.

[4] The category LTC/Nursing homes includes: long term care facilities and extended care facilities.

[3] According to Statistics Canada, a large urban centre consists of a population of 100,000 or more.

IMPLEMENTATION OF A FEDERAL MONITORING AND REPORTING SYSTEM FOR MEDICAL ASSISTANCE IN DYING

Throughout the legislative process leading to the Criminal Code exemption for medical assistance in dying, the importance of a pan-Canadian monitoring system was recognized as a critical component in permitting this service. To this end, the legislation authorizes the federal Minister of Health to make regulations for the purpose of monitoring medical assistance in dying in Canada. The regulations will establish the conditions for collecting and analyzing data, monitoring trends, and providing reports with nationally aggregated information to Canadians.

On December 16, 2017, Health Canada launched a public consultation on draft regulations through the Canada Gazette Part I. The draft regulations outlined the information and reporting requirements for medical practitioners, nurse practitioners, and pharmacists related to requests for, and the provision of, medical assistance in dying. The public consultation period was open for 60 days and closed on February 13, 2018. Health Canada received 43 responses on the proposed regulations. This feedback is being carefully reviewed and will inform the final regulations. A summary report of the feedback is available on Canada.ca.

Health Canada anticipates that Canadian health care professionals will be required to submit information under the new regime in the fall of 2018, with federal monitoring reports from Health Canada using the data derived from the national monitoring regime starting in the spring of 2019.

The data collected under this new federal monitoring and reporting system will provide a more complete picture of who is requesting and receiving medical assistance in dying. This system will enable Canada to align with the standard of public reporting seen in other countries where medical assistance in dying is available. In addition, collecting more robust, nationally comparable data will create a base of evidence that will inform ongoing discussions about medical assistance in dying in Canada. This data will also be made available to qualified researchers upon request, to support independent research and analysis on end-of-life care in Canada. The federal government's monitoring activities, which include the collection, reporting, and sharing of data, are subject to applicable federal legislation and policies that relate to privacy and protection of personal information.